NOTE TO PATIENT:
This consent applies to services provided at:

- **Meriter Hospital for Inpatient and Outpatient Services including Observation and Emergency Services**
- **Meriter Medical Group (MMG) Clinics**

Consent for Treatment/Evaluation

1. I consent to routine diagnostic procedure(s), medical treatment(s) and/or evaluation(s). I understand the purpose of this admission or visit(s).

Medical and Allied Health Care Providers

2. I understand that the physician(s) who treat me and provide my care at Meriter Hospital such as my personal Physician(s), Radiologists, Pathologists, Anesthesiologists, Consulting Physicians, and Surgeons may be independent contractors and may not be agents or employees of the Hospital. I understand that the Hospital is not responsible for the acts or omissions of said physician(s). I further understand that I will receive a separate bill from the physician(s) for their services.

Consent for Billing and Release of Medical Information

3. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made.
4. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.
5. I authorize Meriter Hospital/MMG to release to my insurance provider(s) and/or health care providers any medical information relating to this date of service for billing, insurance processing, quality assurance, or utilization review. The information to be released will be diagnosis and/or documentation of service provided for which charges are made.
6. By providing us with your landline or cell phone number(s), I agree that:
   - I give my consent for Meriter UnityPoint, Health, their agents, and to their collection agents, to contact me at these numbers, or, at any number that is later acquired for me or anyone responsible for my account(s).
   - I may be called by Meriter UnityPoint Health staff or collection agents who may leave live or pre-recorded messages regarding any accounts or services. For greater efficiency, calls may be delivered by an autodialer.
   - I understand I will receive health care services even if I do not provide any phone numbers.

The information to be released may include psychiatric, developmental disability, alcohol or drug abuse information, HIV testing, and AIDS or AIDS related disease diagnosis unless specified:

____

7. I authorize Meriter Hospital/MMG to release billing information to the Guarantor (person responsible for paying bill) as needed for payment for services.

8. I understand that this authorization for releasing information will be effective for one year from the date of my signature unless otherwise stated.____________(Alternative date if not one year), or revoked through written notice to the Health Information Management Department.

Assignment of Benefits

9. I hereby authorize and assign payment to Meriter Hospital/MMG for any type of reimbursement or payment due from Medicare, Medicaid, or any other third party payor, for any and all costs incurred for my medical and related care at this facility provided by this facility and its employees. I understand that I am financially responsible to the Hospital/MMG for charges not covered by insurance.

Please refer to other side for additional information and signature

10. I hereby authorize and assign payment to any independent medical and allied health professionals for any type of reimbursement or payment due from Medicare, Medicaid, or any other third party payor, for any and all costs incurred for my medical and related care provided by those professionals at this facility. I understand that I am financially responsible for charges not covered by insurance.

Teaching Programs

11. I understand that Meriter Hospital/MMG offers educational experience to residents, medical students, and other healthcare profession students, and others with specific health-related learning needs. I authorize these residents and students to observe my care and, if appropriate, participate in that care. I understand that these residents and students are not employees or agents of Meriter Hospital/MMG. The acts or omissions of such residents and students are the responsibility of their sponsoring institutions, not of Meriter Hospital/MMG.

Personal Property

12. I understand Meriter Hospital maintains a safe for the storage of money, jewelry, electronics and other valuables during the patient's stay. The Hospital assumes no liability for the loss of or damage to articles of value unless they are deposited in the safe.

Receipt of Privacy Notice

13. I have received a copy of Meriter's Notice of Privacy Practices which explains how my medical information may be used and disclosed.

Receipt of Patient Bill of Rights

14. I have received a copy of the Patient Bill of Rights information which explains my rights and responsibilities as a patient.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING

______________________________	______________________________ ☐am
Patient's Signature	**Date** **Time** ☐pm
______________________________	______________________________
Signature of Person Legally Authorized to Consent for Patient	Printed Name of Person Legally Authorized to Consent for Patient
______________________________	______________________________
Reason for Signature of Person Other than Patient	Relationship to Patient
______________________________	______________________________
Signature of Interpreter (If applicable)	Printed Name of Interpreter (If applicable)
______________________________	______________________________
Signature of Witness	**Printed Name of Witness**

Meriter Hospital
Meriter Medical Group

CONSENT FOR HOSPITAL/MERITER MEDICAL GROUP INPATIENT/OUTPATIENT/ER/CLINIC SERVICES